APPLICATION FOR ADMISSION

Toll-free 1-877 VETS R US (1-877-838-7787)

IMPORTANT – PLEASE PRINT CLEARLY AND ANSWER ALL ITEMS

I am applying for admission into:

WA Soldiers Home- Orting (near Puyallup) ☐ **WA Veterans Home- Retsil** (Port Orchard) ☐ **Spokane Home** ☐ **Any Home** ☐

I have lived at one of the Homes in the past: **YES** ☐ **NO** ☐ If yes, which Home and when?_____ Date _____

MILITARY INFORMATION:

Branch of Service	Service Number	Date of Active Duty Entry	Date of Separation	Type of Discharge

I heard about the Homes from:
Veterans Organization ☐ Seattle VA Hospital ☐
American Lake VA Hospital ☐ Newspaper ☐
Yellow Pages ☐ Radio/TV ☐ WDVA Website ☐
Other ☐ _____

PERSONAL INFORMATION:

Applicant's name: _____ **Veteran's name, if different**_____
First Middle Last

Physical address: (where you are currently staying):_____

Phone number: (day) _____ (eve) _____ Veteran? Yes ☐ No ☐ Male ☐ Female ☐

Mailing address_____

Date of birth:___/___/_____ **Place of birth**:_____ **Social Security Number:** _____/____/_____ **VA claim:** _____
City/State

Marital status: Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never married ☐

Please answer only the following that apply to your situation: Spouse's name:_____ Date of marriage:_____/_____/____

Date of divorce:_____/_____/_____ Date of separation:_____/_____/_____ Date of spouse's death:_____/_____/_____

Father's name:_____ **Mother's "Maiden" name:**_____

Applicant's next of kin:_____ Relationship of next of kin:_____

Telephone number:(_____)_____ **Address:**_____

Emergency contact (someone who will always know where you are and how to contact you):_____

Relationship of emergency contact:_____ Telephone number:(_____)_____(day) (_____)_____(eve)

(TURN FORM OVER PLEASE) ⇒⇒⇒⇒⇒⇒⇒⇒

INCOME INFORMATION:

Monthly Income	Applicant	Spouse (if applicable)
VA Pension/Compensation	$	$
Social Security		
Retirement – source:_____		
Other income – source:_____		
Other income – source:_____		
Interest from savings, stocks, bonds, CD's		

ASSETS INFORMATION:

Source of Assets	Applicant	Spouse (if Applicable)
Savings Account(s)	$	$
Checking Account(s)		
Cash on hand		
Stocks, bonds, CD's		
Cash value of insurance (do not include insurance that pays only upon death)		
Value of vehicle(s)		
Cash value of residence		
Cash value of real estate (property other than primary residence)		

Have you transferred or assigned real or personal property within 3 years of the date of this application?
Yes ☐ No ☐

If "yes", please provide a description of the property transferred:_____
_____
_____
_____
Date of assignment or transfer:_____
Value of property as of above date:$_____
Reason for transfer or assignment:
_____
_____
_____
_____

I have supplemental health insurance? Yes ☐ No ☐
Insurance Company_____
Monthly premium $_____

I have Medicare Part A: Yes _____ No ☐
Effective date
I have Medicare Part B: Yes _____ No ☐
Effective date
I am currently on Medicaid: Yes ☐ No ☐
I have burial insurance: Yes ☐ No ☐ If yes, what company?_____
Amount of burial $_____
Irrevocable? Yes ☐ No ☐

I am applying for admission to a WA State Veterans Home. I am a resident of the state of Washington. All of the statements on this application are true and complete to the best of my knowledge. I hereby give permission to the WA State Department of Veterans Affairs to do a background check and obtain all information concerning my financial records which include the US Department of Veterans Affairs (VA), Social Security, and other financial institutions. If admitted, I understand that all income, regardless of source, will be considered in the determination of my cost of care. The amount of money I retain for my personal expenses and for my spouse, if applicable, will depend on my income. I understand that all personal expenses and/or prior existing debts are my responsibility. I agree to follow the resident rules of conduct and all policies and procedures of the Department of Veterans Affairs.

_____ _____
Applicant's signature **Date**

_____ _____
Witness' signature if signed above with an "X" **Date**

_____ _____
Witness' signature if signed above with an "X" **Date**

CHECK LIST OF DOCUMENTS NEEDED FOR APPLICATION

Note, if any of the documents below apply to you, please send copies only of the documents not originals!

Birth Certificate	
All Marriage Certificates and/or Divorce Decrees	
Social Security Card	
Medicare Cards for you and your spouse	
Current Bank Statements for **all** accounts	
All Insurance Policies - Including Life, Burial and Medical	
If you or your spouse have any Stocks, Bonds, Mutual Funds, Money Market, or Certificates of Deposit	
Award Letters or Pay Vouchers for Civil Service, Union Pensions, Social Security, Retirements, Annuities, Veteran Compensation/Pension, etc.	
If you worked for any union, verify if you have any Death/Medical Benefits	
If you pay for Medical Insurance, supply proof	
Power of Attorney/Fiduciary/Guardianship papers	
Verify all Transfer of Assets within 36 months	
Real Estate Contracts you have	
Discharge Certificate or DD214	

Washington State Department of Veterans Affairs
Health Care Facilities

Date: _____

FROM: CENTRALIZED ADMISSIONS
PO BOX 199
ORTING WA 98360

TO: _____

_____

_____

SUBJECT: Release of Medical Information from the Records of

Name Date of Birth SSN

_____

INFORMATION REQUESTED:
MEDICAL RECORDS RELATED TO RECENT INPATIENT/ OUT PATIENT/ NURSING HOME TREATMENT FOP, DIAGNOSIS LISTED ON ATTACHED MEDICAL CERTIFCATE.

I, _____
an applicant for admission to the Health care facilities of the Washington State Department of Veterans Affairs (WDVA), hereby give my permission and do request that you furnish the WDVA with -any and all information from my medical records at your facility. This authorization does include: Laboratory Studies, Psychiatric-Evaluations, Narratives, Summaries, Diagnoses and Prognoses, Social Work Assessments and/or Discharge Plan and any treatments for Alcohol and/or Drug Abuse.

I do understand the purpose of this information is to make final approval for admission and determine appropriate level of care needs.

Confidentiality of all records provided will be in accordance with WAC 24&100-016.

Send this form in with the Admission Application. Failure to do so will delay the application process.

_____
Signature of Applicant

DVA 139 Rev.3/93

WASHINGTON STATE DEPARTMENT OF VETERANS AFFAIRS

CONSENT FOR INPATIENT & OUTPATIENT TREATMENT

I, the undersigned, hereby consent to such x-ray examination, laboratory procedures, medical or minor surgical treatments, physical or occupational therapy, nursing services, and other services that may be rendered to me, under the general and special instructions of the attending physician or his/her assistant or designee.

I understand that my care is under the control of my attending physician, and the home is not liable for any act or omission in following their instructions.

I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made to me as to the exact results of treatments or of examinations.

This form has been fully explained to me. I have read it or it has been read to me and I understand its contents.

This consent is valid for as long as I am a resident of the Washington State Soldier's Home and is applicable to each and every inpatient and outpatient treatment.

I acknowledge receipt of a copy of this form.

_____	_____	_____	_____
Resident's Signature or Legal Guardian	Date	Witness	Date

Patient's Name: _____

DVA Number: _____

Physician's Name: _____

WASHINGTON STATE DEPARTMENT OF VETERANS AFFAIRS

CONSENT FOR MEDICAL SERVICES

MEDICARE PATIENTS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or the Professional Standards Review Organizations, or any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance for Secondary Insurance/Payment Policy: I authorize my insurance benefits to be paid directly to the Washington Veterans Home. The Washington Soldier's Home will bill my insurance company (ies) directly.

This agreement will remain in effect until such time as I am no longer a resident of the Washington Soldier's Home.

The signature of the resident is required except under the following circumstances:

1. If the resident is incapacitated, a legal guardian, relative, or a representative designated by the Social Security Administration may sign the form explaining their relationship to the resident and the reason for the resident's inability to sign.
2. If the resident is unable to write, he may sign by making a mark (X) in the presence of a witness. The **signature** and **address** of the witness must also be given. The witness may not be a member of the Washington Soldier's Home Staff.
3. If the resident is deceased then no signature is necessary, but date of death should be indicated.

I, _____ SSN# _____ hereby authorize WSH, its contractors and service providers, to apply for benefits on my behalf for covered services rendered. I request payment from Medicare carrier to WSH, its contractors and service providers.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including information for this or any related claim, to the Medicare carrier, the above named billing agents, (or in the case of Medicare Part B benefits), to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original.

This authorization may be revoked, at anytime, in writing, by either the Medicare Carrier or me.

Resident Signature_____Date_____

If none, explanation for inability_____

Guardian/Relative/SSA Rep/Witness Signature _____Date_____

Relation to Resident_____Address_____